PATIENT IDENTIFICATION LABEL

Staff to tick & initial to indicate Clinical Handover at Point of Care	From: Reception	To: Admission Nurse
Patient ID & Procedure Match		
Alerts		
Medicare status		
Special requirements-including language		
Initial to indicate Clinical Handover at this Point of Care		

PATIENT ADMISSION DETAILS

Admitting Doctor/Surgeon:

General Practitioner (Name and Address)

Date of Admission:

Operation/Procedure:

Have you been hospitalized anywhere in the last seven days? Yes□ No□ If yes, where?

PATIENT DETAILS – Please print as your name appears on Medicare Card

Title: Mr/Mrs/Ms/Miss	Surname:	Previous Surname:

Given Name:

Address:	Postcode:

Phone (H)	(M)	(B)
Sex: Male□ Female□	Date of Birth:	Marital Status:

Country of Birth (if Australia, which state)	Are you an Australian Resident? Yes□ No□ Are you of Aboriginal/Torres Strait Island Descent? Yes□ No□

Medicare number:	Reference No:	Expiry Date:	Veteran's Affairs No.

Pension No. Health Care Card	Expiry Date:

Private Health Fund:	Membership Number:

Email address:

Next of KIN (Person to contact in case of Emergency)

Name:	Relationship:

Contact No.

ESCORT CONTACT DETAILS (Who will be taking you home?)

Name:	Relationship:

Contact No.

Charter of Rights: I have read and understand my rights as per Rights & Responsibilities Information provided by SEC

Patient Signature:

PRE-ANAESTHETIC ASSESSMENT

Patient to complete. Admission Nurse to review with patient at time of pre-operative assessment, then handover to Doctors prior to consultation.

PATIENT ID LABEL

1. Medical History

Have you ever had any of the following complaints?
If yes to any of the above please give details:

____
____

	Yes	No
High Blood Pressure		
Heart Attack		
Blood clotting problems		
Angina		
Stroke		
Rheumatic Fever		
Blood clot in legs or lungs		
Kidney Disease		
Diabetes	Type 1/ Type 2	
Anaemia		
Pneumonia or Tuberculosis		
Hepatitis or Jaundice		
Eczema / Hay Fever		
Asthma		
Obstructive Sleep Apnoea		
Epilepsy or fitting		
Prosthetic Joints		
Heart Valve Replacement		
Recent Cold or Flu like illness		
Other serious illness		

	Yes	No
Do you smoke? How Many? Last smoke?		
Do you drink Alcohol? How much per day?		
Have you had a recent hospital stay?		
Have you been in to hospital overseas in the last 12 months?		
Have you had any falls in the past 3 months?		
Have you had any significant weight loss in the last 3 months?		
Have you had a high temperature in last week?		
Females, Are you Pregnant? If Yes, what is the EDC		
Do you require any assistance with mobility or use any aids such as walking stick, frame?		
Do you have any issues with skin integrity such as ulcers, skin tears, lesions or wounds?		
Do you need help to communicate? Hearing or seeing, cognitive impairment?		
Do you require an interpreter? If so what language?		
Any other medical issues:		

2. Allergies

Do you have any allergies? Yes No
If Yes, ____

3. Medications

Please list your current Medications

____
____
____

4. Surgical History

Have you had any previous operations? Yes No
Details:

Operation	Year

5. Anaesthetic History

Have you or a family member had an anaesthetic complication?
Yes No
Details:____
____
____

OFFICE USE ONLY:

Height:___________Weight:___________BMI: _________

Prep instructions followed correctly: Yes No

Do you take blood thinner medication? Yes No

If yes, medication:______________Last taken: _______

Time of last food:______________________________
Time of last drink: ______________________________
Suitable escort arrangements:____________________________________
Nursing Notes:
____
____
____

Staff to tick & initial to indicate Clinical Handover at Point of Care	From: Nurse	To: Endo	To: Anaes
Patient ID & Procedure Match			
Alerts/Allergies			
Relevant Medical history			
Fasted and Prep completed correctly			
Special requirements-including language, skin issues, mobility			
Suitable escort arrangements			
Initial to indicate Clinical Handover at this Point of Care			

Nurse Signature:__________________ **Name:**____________________